

Appendix D. Full set of derived CMOC/full programme theory.

The need for FGM knowledge and awareness:

- 1) Lacking knowledge or skills (including about the cultural contexts of FGM, safeguarding requirements, who might be affected, and the different types of FGM and their clinical consequences) impacts on GPs' ability to provide optimal care for women affected by FGM. Practitioners may not be aware that they lack knowledge, including which patients may be affected and their care needs (C). This lack of knowledge (M) results in their inability to meet their care needs. (O) (1-23).
- 2) Lacking the necessary knowledge and skills (C), is associated with a lack of confidence (M) which impacts on clinical care for women with FGM (O) (10, 24, 25). This includes having the knowledge and confidence to consider who may be at risk (26).
- 3) Feeling that they have adequate knowledge (including how to respond to a disclosure) (C) helped clinicians feel confident (M) to ask to ask (O) (27, 28).
- 4) Women who perceive healthcare professionals lack knowledge and skills to manage FGM (C), or who have experienced stigma (C) may lack confidence that health services (M) will meet their care needs (O) (5, 10, 24, 29-33).
- 5) (C)Health professionals experience emotional reactions to encountering FGM such as anger, shock, and pity; they find encountering FGM without adequate knowledge is "frightening"(35)(M). Professionals try to hide their reactions but are aware their reaction may be apparent to the women (21, 23, 34-37) (O).
- 6) Community members see health care providers reacting with shock or horror to their FGM (C). This provokes feelings of shame (M) which reduces their likelihood of accessing services (O) (22, 38-42) .
- 7) However, clinicians confident in managing FGM (C) are able to reassure women (M) and meet their care needs (O) (28, 43, 44).
- 8) Healthcare professionals may experience a strong emotional responses to FGM (C). This may make them feel panicked or frightened (M) and abandon their usual routines and practices (O) (28, 93).
- 9) FGM is usually a relatively small part of the GP workload (C). GPs may not identify learning about FGM as a priority (M) for themselves. The GPs then lack knowledge and skills (O)(45,46).
- 10) Clinicians who encounter FGM more frequently in the line of their work (C), may become sensitised to FGM (M) and motivated (M) to learn more or develop their knowledge and skills (O). The converse may also be true (8, 12, 14, 47).
- 11) FGM can be difficult to correctly identify (48), especially types 1 and 4 and associated with less symptoms (C) and GPs may not have the expertise or confidence (M) to correctly identify or manage FGM (O) (20, 49-53).

Talking about FGM and communication:

- 12) A key skill GPs need is being able to talk about FGM sensitively). Fears (M) of offending women by not knowing how to raise the issue(C) can lead GPs to avoid talking about FGM (O) (4,, 10, 16, 21, 22, 23, 29, 35, 48, 54-57) .
- 13) Professionals who understand that FGM can be sensitive or taboo subject (C) may be fearful of offending women (M) and avoid discussing FGM with women (O) (23,29,54, 55, 58,59). This contextual factor may be evolving as community attitudes towards the practice of FGM change including meaning that talking about FGM is less taboo in some communities (37, 60-64, 92).
- 14) Not being aware of or not recognising evolving community practices (C) risks (M) offending community members thereby reducing effective communication/consultations (O) (37). Or that professionals are not able to accurately appraise risk (11) (61).
- 15) Raising FGM in a way that is normalised within the consultation, for example as a standard question on an assessment form (C) may reduce the embarrassment (M) and facilitate asking (O) (23). Prompts in the records may help clinicians to do this (23, 65).

- 16) Challenges around the use of terminology can complicate communication between GPs and their patients affected by FGM. Some women may find the terms FGM offensive or frightening , or if the term FGM is not familiar to the woman (C) , or she does not align her cultural practice (for example labial elongation) with FGM (C), then she may not relate her experience to FGM (M) or know how to reply if a GP asks her about FGM(O) (O) (66-70).
- 17) Women's experiences of poor communication and difficulties in engagement with health professionals (e.g. language, cultural differences, perceived judgement), and including non-verbal communication, led to them feeling not understood or respected (M), causing a lack of confidence and trust in health services (O) (21, 29, 30, 39, 71, 72).
- 18) Women who feel pitied or judged(C) may be reluctant (M) to make a disclosure to a health care professional (O) (73, 74).
- 19) Members of communities affected by FGM acting as health advocates (C) may help promote trust and educate communities and professionals (M) to facilitate access to services (O) (75-77).
- 20) Language barriers and a lack of understanding of how the health setting works, including communicating with primary care receptionists (C) can make accessing services difficult or stressful (M) and lead to avoidance (O) (78).
- 21) Whether FGM is relevant to the health concern which the woman brings to her GP appointment (C), could impact on whether the GP or woman are willing to raise or discuss FGM (M), and how such a conversation may be received or experienced (O) (36, 37, ,60, 67, 79). This may apply when GPs consider asking women about FGM to consider safeguarding needs within their families, rather than because of their own health needs (27, 37, 80,81)) .
- 22) Coding FGM into medical records introduces potential tensions around balancing the needs of the woman (and her confidentiality) with the potential need of her family (C) which may cause confusion or uncertainty for GPs (M), and lead to improvised strategies or inconsistent coding (O) (81- 83).
- 23) Women who perceive that the HCP is preoccupied with their FGM (C), can feel disrespected (M) and disengage with health care settings (O) (37,60, 84, 85) .
- 24) GPs gender (C) may influence whether the woman or GP feel it is culturally appropriate (M) to talk about FGM (O) (23,38, 55, 86).
- 25) Time pressures in the consultation (C) mean GPs may be reluctant (M) to discuss FGM (O). (23, 46, 55, 87)
- 26) Language barriers are a significant context which influence the conversations between GPs and women about FGM (C) which reduce communication (M) between women and GPs with impacts on communication effectiveness and their care (O) (4, 17, 21,23, 29, 55, 57, 58, 78, 86, 88).
- 27) Strategies to address language barriers add their own complications. Official interpreters are recommended, but may not be available or trusted by women, for example if they both perceive FGM as taboo, or she fears they will not respect her confidentiality. This can lead to fear (M) and reduced engagement with health professionals (O) (4, 6, 17, 23,29, 35, 36, 38, 55,56, 89,90).
- 28) The presence of family members (as interpreters, or witnesses) in the consultation (C) may inhibit GPs feeling able to raise FGM (O) with the women, because of concerns about privacy and confidentiality (M) (4, , 55, 58, 91).

The need for guidelines and access to specialist services:

- 29) Researchers and commentators suggest that having access to clear and supportive guidelines about what clinicians should do (C) will enable professionals (M) to ask women about FGM and optimise their care (O)(19, 20,35,92,93). Even when guidelines exist, awareness of them may be incomplete, or they may not be followed, as demonstrated by four UK hospital studies (47, 56, 57, 94). The reasons for this in the case of FGM warrant exploration. Having prompts to normalise asking about FGM may help clinicians broach the subject (95), especially if linked to training or referral pathways(96).

- 30) FGM is a complex area for health care professionals to manage, and this management may include needing to report women and their families to other authorities. If professionals are developing awareness of FGM, without accompanying guidance (C), they may experience uncertainty and face what they experience as ethical tensions (M) and risk making incorrect or uncertain decisions regarding reporting (O) (92,93)
- 31) Lacking guidance, including guidelines and certainty about what good care comprises (C) can lead to practitioners feeling uncertain (M) and improvising how they offer care (O) (22, 23).
- 32) Knowing how to react or having access to specialist services (C) may help GPs and community members feel confident (M) to talk about FGM (O) (23, 29, 52, 53, 72, 97).
- 33) When Health care professionals speak about FGM within a framework of offering support and services (C), it is more likely to be experienced as acceptable by the woman (M, O) (64).
- 34) Training is more likely to be effective (C) in changing behaviour and promoting asking (O) when it is supported by resources and referral pathways or protocol for intervention (M) (28, 73, 96, 98). Specialist access may be especially important to support practitioners in low prevalence areas (23).

Mandated actions including mandatory reporting and the FGM Enhanced dataset requirements:

- 35) The mandatory reporting duty (C) may cause distress and reduce trust (M) in professionals which may deter women from seeking help or disclosing their FGM (O) (52, 55, 60, 62, 99-101).
- 36) Concerns that medical encounters or records are not confidential may cause fear/apprehension (M) and deter women from a disclosure of her needs or concerns (O) (46, 91, 102).
- 37) The requirement to submit personally identifiable data to the FGM enhanced dataset (C) may reduce women's trust in the confidentiality of the GP consultation (M) and make her reluctant to disclose FGM (O) or make GPs reluctant to raise FGM (O) because of concerns about confidentiality (M) (55, 60, 75, 103-106).
- 38) The ways in which mandatory reporting or the enhanced dataset are raised in the consultation, including when this happens repeatedly (C), may lead women to feel that the professionals' interest is more in data collection than them, or make them feel judged or fearful (M), and avoid attending healthcare altogether (O) (60)
- 39) The concern (M) that making a mandated report (C) would have a potentially negative impact on trust (O) in on-going professional relationships (O) was an important potential consideration for professionals (107-110) and identified as a potential deterrent for help seeking (108,111).
- 40) Another concern about managing the legislative requirements includes that FGM can be difficult to identify on examination. GPs may feel that they do not have the skills needed to identify or manage FGM and so not feel confident in being able to identify FGM to confidently code it (O)(48-50) (46), which may impact on data accuracy (O) (112). Education (C) is needed to help practitioners feel able (M) to approach mandatory reporting (O) (122).
- 41) Practitioners making mandated reports need to feel confident that their report will be adequately responded to, without causing harm (113-114). They may be helped by training (113).
- 42) In addition to lack of knowledge or training (C), practitioners may have concerns about confidentiality (C/M) or fear of causing stigma (C/M) which leads to incomplete or inaccurate coding of FGM (115). Practitioners may perceive a need to feel certain (C) before making a mandated report (O) so that they do not risk making a mistake (M)(116-117).
- 43) When young people know that the professional whom they are speaking to is mandated to share the information with other authorities (C), they may feel more reluctant to trust the professional (M), and less likely to make a disclosure (O) (118).
- 44) A Perceptions of how trustworthy the authority being referred onto may contribute to decisions as to whether or not to disclose. Those who are potentially fearful of authorities or perceive themselves to be vulnerable (C), for example those with uncertain migrant status (C), or if they fear that their disclosure risks placing others at risk of trouble (c), may be more fearful of mandatory reporting or data sharing (M) and avoid accessing services (O) (107)(119-124)

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